STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005010	A. BUILDING: _____ B. WING _____	C 05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT KOKOMO	1907 W SYCAMORE ST KOKOMO, IN 46904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of a State complaint. Complaint Number: IN00198188 Unsubstantiated: Lack of sufficient evidence. Date: 5-12-16 Facility Number: 005010 St Vincent Kokomo is in compliance with 410 IAC 15-1.5-5, Medical staff and 410 IAC 15-1.5-6, Nursing service, Indiana Hospital Licensure Rules. QA: cjl 05/17/16	S 000		